

Department of Health and Human Services Public Health Services						LEAVE BLANK—FOR PHS USE ONLY.						
Grant Application <i>Do not exceed character length restrictions indicated.</i>						Type	Activity	Number				
						Review Group		Formerly				
						Council/Board (Month, Year)		Date Received				
1. TITLE OF PROJECT (<i>Do not exceed 81 characters, including spaces and punctuation.</i>)												
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION NO YES (If "Yes," state number and title) Number: _____ Title: _____												
3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR						New Investigator	No	Yes				
3a. NAME (Last, first, middle)						3b. DEGREE(S)			3h. eRA Commons User Name			
3c. POSITION TITLE						3d. MAILING ADDRESS (<i>Street, city, state, zip code</i>) E-MAIL ADDRESS:						
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT												
3f. MAJOR SUBDIVISION												
3g. TELEPHONE AND FAX (<i>Area code, number and extension</i>) TEL: _____ FAX: _____												
4. HUMAN SUBJECTS RESEARCH No Yes		4b. Human Subjects Assurance No.				5. VERTEBRATE ANIMALS No Yes						
		4c. Clinical Trial No Yes		4d. NIH-defined Phase III Clinical Trial No Yes		5a. If "Yes," IACUC approval Date		5b. Animal welfare assurance no.				
4a. Research Exempt No Yes		If "Yes," Exemption No.										
6. DATES OF PROPOSED PERIOD OF SUPPORT (<i>month, day, year—MM/DD/YY</i>) From _____ Through _____				7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD			8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT					
				7a. Direct Costs (\$)		7b. Total Costs (\$)		8a. Direct Costs (\$)		8b. Total Costs (\$)		
9. APPLICANT ORGANIZATION Name _____ Address _____						10. TYPE OF ORGANIZATION Public: → Federal State Local Private: → Private Nonprofit For-profit: → General Small Business Woman-owned Socially and Economically Disadvantaged						
11. ENTITY IDENTIFICATION NUMBER DUNS NO. _____ Cong. District _____												
12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE Name _____ Title _____ Address _____ Tel: _____ FAX: _____ E-Mail: _____						13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name _____ Title _____ Address _____ Tel: _____ FAX: _____ E-Mail: _____						
14. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.						SIGNATURE OF PI/PD NAMED IN 3a. (In ink. "Per" signature not acceptable.)					DATE	
15. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.						SIGNATURE OF OFFICIAL NAMED IN 13. (In ink. "Per" signature not acceptable.)					DATE	